significance is concerned, for very seldom if ever is there seen in the market lettuce or celery free from dirt, and even in well managed households and public eating places scrupulous care in preparing articles for the table is exceptional.

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TYPHUS FEVER IN THE UNITED STATES.

In last week's issue of the Public Health Reports there appeared under the title "The relation of so-called Brill's disease to typhus fever," a report of work done by Passed Asst. Surgs. Anderson and Goldberger, which shows that the so-called Brill's disease is identical with the typhus fever of Mexico. The typhus fever of Mexico is very probably the same as the typhus fever of Europe and Asia, and presumably the infection known to exist in New York, and understood to have occurred in other large cities, was imported by European or Asiatic immigrants. This gives the American physician a new disease with the symptoms of which he should familiarize himself, and the possible appearence of which among patients he should keep constantly in mind. To the health authorities of the United States it presents a new infectious disease for consideration and control.

From 1896 to the end of 1910 Dr. Nathan E. Brill noted among the medical patients in one hospital in New York City 255 cases of a disease which in general symptoms resembled typhoid fever to some extent, and which very probably has usually been so diagnosed. Dr. Brill, however, clearly differentiated the two diseases, and in various reports drew attention to the similarity of his cases to typhus fever. That the disease could be typhus fever, however, he could hardly believe, because of its mildness and low fatality. Among the 255 cases which he had observed there was but one death.

In addition to the cases reported by Brill, Dr. Leon Louria reported 18 cases observed during the summer and autum of 1910 in one hospital in Brooklyn.

The fact that cases of typhus fever have been confused with typhoid fever in New York City, and that they are without doubt being so confused in other large cities, is of interest in view of the fact that originally these two diseases were both included under typhus fever and no differentiation was made between them. Gerhard and Pennock, of Philadelphia, are commonly given credit for having in 1837 first definitely established that typhoid fever and typhus were distinctly separate entities.

The clinician has at all times found difficulty in diagnosing mild cases of even the more common diseases. Some of this difficulty is inevitable, but much of it has been due to the fact that the usual descriptions of a disease given in the literature are of its more severe manifestations, which are assumed to be usual and typical and frequently pathognomonic. The natural result of this is that very probably certain diseases are recognized only in their more virulent and at

times less common form. It took some time for the practitioner to readjust his ideas so that he recognized as smallpox the many mild cases occurring in this country, and many of these are still being overlooked. In yellow fever the mild cases, which are probably common during epidemics and in endemic centers, are without doubt not recognized. The same is true of cholera, and our mental pictures of these diseases are very likely those of the more severe forms only. The same may be assumed to be true of many other diseases.

The classical descriptions of typhus fever have not proven sufficient for the identification of the mild type of the disease present in this country, even by so well informed and accurate an observer as Brill. For the convenience, therefore, of those who have not had the opportunity of observing this mild and, compared with the usual descriptions given, atypical form of the disease, the following parallel comparison of the symptoms with those of typhoid fever, with which it is most apt to be confused, is taken from an article by Dr. Brill in the American Journal of the Medical Sciences for April, 1910, Volume CXXXIX, page 500:

TYPHOID FEVER.	BRILL'S DISEASE—TYPHUS FEVER.
Usually long incubation.	Short incubation, four to five days.
Onset not commonly abrupt	Commonly with chill or chilly sensation.
Fever; gradually increasing ascent of temperature to fastigium—in all, about 10 days.	Fastigium reached in three days.
Remissions of temperature occasionally more than a degree.	Rarely more than 1 degree.
Fall usually by gradations to normal, taking commonly one week.	Fall commonly by crisis, not longer than 60 hours.
Eruption, circumscribed, lenticular, papular.	Maculopapular, periphery indistinct and irregular.
Distribution, chiefly, back, and abdomen, seldom appearing on upper and lower extremities; almost unknown on palms and soles.	Distribution in addition to trunk on upper and lower extremities not infrequent, on palms and soles occasionally.
Eruption appears in crops throughout the disease.	Does not appear in crops.
Spots rarely confluent, and then confluence of but two spots.	Confluence may occur with three or four spots forming a number of patches.
Roseola disappearing on pressure.	Erythema, not disappearing on pressure.
Petechial spots (hemorrhagic) very rare.	Petechiæ occasionally.
Apathy and prostration late in development.	Apathy and prostration early.
Labial herpes rare.	Labial herpes in 6 per cent of the group.
Diarrhea fairly common.	Constipation an almost invariable accompaniment.
Hemorrhages from the bowel often observed.	No intestinal hemorrhages or blood in feces.
Headache disappears in second week.	Is more intense and lasts throughout the disease.
Relapses observed by all observers.	Relapses have never occurred.
Widal reaction positive in over 95 per cent of the cases.	Widal reaction invariably absent.
Blood cultures positive in over 90 per cent of the cases.	Blood cultures invariably negative.
Convalescence slow.	Convalescence speedy.

MEASURES FOR PREVENTION.

Both the old world typhus and that of Mexico have been experimentally given to monkeys by the bites of body lice which had previously bitten infected monkeys or human patients suffering with the disease. The body louse is therefore to be considered as a possible, and probably the usual, agent by which the disease is carried from individual to individual. This comparatively recent addition to our knowledge of typhus fever offers an apparent explanation of the diminished frequency of its occurrence in jails and other institutions in which outbreaks were at one time so common in certain countries that the disease was known as jail fever. Typhus fever does not seem to be spread by fomites nor by direct contact unless the contact is such that the exchange of body lice is possible. Wherever cases occur measures should be taken to eliminate the possibility of infected body lice spreading the disease.